Balance Assessment and Case History

Name:_____ Age:_____ Date:_____

The purpose of this questionnaire is to obtain information that pertains to your dizziness and/or unsteadiness. Please answer all the questions according to their directions and be as thorough as possible.

I. When you are "dizzy," do you experience any of the following sensations? Please read the entire list first. Then place a "√" in the box of sensations below that describe your feelings most accurately.

- ❑ 1. Light-Headedness.
- ❑ 2. Swimming sensation in your head.
- ❑ 3. Headache or head pressure.
- ❑ 4. Loss of equilibrium.
- ❑ 5. Blacking out.
- ❑ 6. Loss of consciousness.
- ❑ 7. Loss of balance when walking. Veering to the right.
- ❑ 8. Loss of balance when walking. Veering to the left.
- ❑ 9. Tendency to fall to the right.
- ❑ 10. Tendency to fall to the left.
- ❑ 11. Tendency to fall forward.
- ❑ 12. Tendency to fall backward.
- ❑ 13. Sensation that you are turning or spinning, with objects remaining stationary.
- ❑ 14. Objects spinning or turning around you with your eyes open.
- ❑ 15. Objects spinning or turning around you with your eyes closed.
- ❑ 16. Visual blurring during head motion.
- ❑ 17. Spinning or turning sensation when you lie down.
- ❑ 18. Spinning or turning sensation when you roll to the right side.
- ❑ 19. Spinning or turning sensation when you roll to the left side.
- ❑ 20. Nausea or vomiting.

II. Please answer the following questions.

1. When did the dizziness first occur?

2. Are you getting better?

3. How often does the dizziness occur?

4. Is the dizziness constant?

5. Does the dizziness come in attacks?

6. How long do the attacks of dizziness last?

7. Are you completely free of dizziness between attacks?

8. Do you have any warning that an attack is about to start? If so, what?

9. Does your dizziness only occur in certain positions? If so, what?

10. When you are dizzy, must you support yourself when standing?

11. Have you ever stumbled or fallen because of your dizziness?

12. Do you know of anything or anything that will:

Stop your dizziness or make it better? If so, what?

Make your dizziness worse? If so, what?

Cause of dizziness? If so what?

13. Have you ever injured your head?

14. Have you ever had ear surgery?

15. Have you ever been unconscious?

16. Current medications including prescription medication, OTC, herbals, vitamin/mineral/dietary nutritional supplements) including dose and frequency

17. Do you use tobacco of any form?

_____

18. How many cups of regular coffee, tea or sodas do you drink each day?

_____

III. Place a "√" in the box if you have any of the following symptoms:

- ❑ 1. Changes in your hearing when you are dizzy.
- ❑ 2. Difference in the pitch of sounds.
- ❑ 3. Distortion in hearing.
- ❑ 4. Noise or ringing in your ears.
- ❑ 5. Changes in the noise or ringing in your ears when you are dizzy.
- ❑ 6. Fullness or pressure in your ears.
- ❑ 7. Pain in your ears.
- ❑ 8. Dizziness with exertion or overwork.
- ❑ 9. Dizziness when you have not eaten for a long period of time.
- ❑ 10. Dizziness with your menstrual period.
- ❑ 11. Diabetes.
- ❑ 12. High blood pressure.
- ❑ 13. Neck injury.
- ❑ 14. Changes in dose or medication of your current medications.
- ❑ 15. Stroke/vascular incident
- ❑ 16. Multiple Sclerosis
- ❑ 17. Cancer
- ❑ 18. Coronary heart disease
- ❑ 19. Autoimmune disease

IV. **Do you ever experience any of the following symptoms? Please circle yes or no and constant or in episodes.**

Yes	No	1. Double vision	constant	in episodes
Yes	No	2. Numbness in face or extremities	constant	in episodes
Yes	No	3. Blurred vision or blindness	constant	in episodes
Yes	No	4. Weakness in arms and legs	constant	in episodes
Yes	No	5. Clumsiness in arms or legs	constant	in episodes
Yes	No	6. Confusion or loss of consciousness	constant	in episodes
Yes	No	7. Difficulty with speech	constant	in episodes
Yes	No	8. Difficulty in swallowing	constant	in episodes